

# Hurricane Katrina: Medicaid Issues

Updated December 29, 2005

Congressional Research Service

<https://crsreports.congress.gov>

RL33083

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid can present an enormous challenge in meeting the needs of Hurricane Katrina's victims, especially when evacuees cross state lines. State variation in eligibility, covered services, and the reimbursement and delivery of services is the rule rather than the exception. Furthermore, although Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor.

As a federal-state program that helps to finance health care services for people with limited resources, Medicaid is an obvious avenue of quick response for support of victims in the aftermath of a disaster. The program's federal budgetary status as mandatory spending means that federal funding is available to support coverage for all people who meet the program's eligibility criteria, without the need for a supplemental appropriation.

However, the ability of Medicaid to respond to a disaster—in terms of the numbers and types of people who can rely on it for health care support—may depend on a number of factors, including congressional action to modify statutory provisions (e.g., the level of federal Medicaid reimbursement offered to states), the Secretary of Health and Human Services' ability to waive certain program requirements administratively (e.g., regarding eligibility and benefits), and actions of the states (each of whom operates its own unique Medicaid program within federal guidelines).

This report, which will be updated as events warrant, discusses the following:

- Medicaid's rules on eligibility, benefits, and financing in the context of current questions and issues raised by Hurricane Katrina.
- Recent state actions in response to Medicaid issues raised by the hurricane.
- Federal Medicaid waiver authority, including information on current activity in this area and the New York Disaster Relief Medicaid waiver granted in response to the September 11 terrorist attacks.
- Current federal legislation related to Medicaid and Hurricane Katrina relief efforts.

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## Overview

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid can present an enormous challenge in meeting the needs of Hurricane Katrina's victims, especially when evacuees cross state lines. State variation in eligibility, covered services, and the reimbursement and delivery of services is the rule rather than the exception. Furthermore, although Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor.

While some of the federal rules governing Medicaid are flexible enough to allow states to act without federal intervention in the wake of Hurricane Katrina, certain issues raised by the disaster may be addressed only through administrative or legislative action by the federal government. On the administrative front, the Centers for Medicare and Medicaid Services (CMS) has developed a voluntary Medicaid waiver option to address some of the hurricane-related eligibility and benefit issues raised in this report.

On the legislative front, congressional action may be required if enhanced federal reimbursement is to be provided to states for Medicaid costs incurred as a result of Hurricane Katrina. Congress may also consider the desirability of uniform treatment of hurricane victims across states (rather than relying on participation in the waiver program developed by CMS). A number of bills that would provide Hurricane Katrina Medicaid and SCHIP relief have been introduced.

This report begins with a discussion of Medicaid's rules on eligibility, benefits, and financing in the context of current questions and issues raised by Hurricane Katrina, many of which could arise in the wake of other emergency situations (e.g., Hurricane Rita). It then provides information on recent actions taken by states, discusses federal Medicaid waiver authority, and describes current federal legislation dealing with Medicaid and hurricane relief efforts.

## Medicaid Eligibility and Access

### Background

In general, to qualify for Medicaid coverage, an individual must meet both categorical and financial eligibility requirements. Categorical eligibility requirements relate to the age or characteristics of an individual. Categories of individuals that may qualify for Medicaid generally include aged persons (65 and over), certain persons with disabilities, children and their parents, and pregnant women. In addition, within federal guidelines, states set functional requirements for individuals seeking Medicaid-covered long-term care services.

Financial requirements govern the amount of income and assets that categorically eligible individuals may have and still qualify for Medicaid, as well as how these amounts are calculated (e.g., whether a portion of earned income or the value of a car may be disregarded). The specific income and asset limitations that apply to a particular group are determined through a combination of federal requirements and state options. Consequently, different standards apply to different groups, and the standards themselves may vary considerably among states.

Individuals who do not meet categorical eligibility requirements (e.g., non-elderly adults who are not disabled and do not have children) generally cannot qualify for Medicaid coverage even if they are poor. However, as discussed later in this report, Section 1115 waivers (which allow the Secretary of Health and Human Services (HHS) to waive certain statutory Medicaid requirements

for purposes of conducting research and demonstration projects) provide exceptions to these eligibility rules for states that have obtained an approved waiver.

## **Issues Raised by Hurricane Katrina**

People who are currently eligible for their state's Medicaid program may face difficulty accessing health care services if they have lost their Medicaid cards and other identification or have been evacuated from their home state. In addition to creating problems for those who are current Medicaid enrollees, the large losses of Hurricane Katrina's victims may also swell the numbers of people who are financially eligible for Medicaid, either in their home state or in the state to which they have been evacuated.

### **Residency**

Current federal Medicaid rules governing residency help in understanding which program is the right one for evacuees to appeal to if they believe they are Medicaid eligible. State Medicaid programs are required to provide coverage to all state residents who are otherwise eligible for Medicaid. An individual is generally considered a resident of a state if he or she is living in it with the intention of remaining there permanently or indefinitely. Eligibility may not be denied because an individual has not resided in the state for a specified period or because the individual is temporarily absent from the state. A state is also prohibited from denying coverage to an individual who satisfies residency rules but who did not establish residence in the state before entering a medical institution.

For currently enrolled Medicaid recipients who have been displaced from their home state, the home state is *required* under certain circumstances to pay for covered services (i.e., covered under the home state's Medicaid program) furnished in another state to the same extent that it would pay for services furnished within its boundaries and may *opt* to pay for out-of-state services under other circumstances (see the Payment and Financing section of this report for additional information). However, the Medicaid recipient must find an out-of-state provider willing to accept Medicaid payment from the home state (as well as enroll or otherwise enter into an agreement with the home state's Medicaid program as a condition of receiving that payment), and not all providers may be willing to do so.

Regardless of whether they are enrolled in Medicaid in their home state, displaced individuals might wish to be considered residents of the state to which they have evacuated, either to obtain Medicaid coverage (in the case of those who were not previously eligible) or to facilitate access to care (in the case of those who were eligible for Medicaid in their home state but are having difficulty finding a provider that will accept their out-of-state coverage). If an individual meets the residency requirements described above and is otherwise eligible for Medicaid in the state to which they have evacuated, coverage cannot be denied. However, it should be noted that the eligibility and benefit rules of an individual's host state may be different than the rules of his or her home state.

### **Income and Asset Documentation**

In general, federal law stipulates few documentation requirements for Medicaid applicants. State policies on this issue vary based on the eligibility group, but a considerable amount of documentation may be required to determine whether an individual meets financial eligibility

requirements for Medicaid.<sup>1</sup> Although states have flexibility to collect income and asset information through self-declaration alone, they also have the ability to require supporting documentation.

Federal law does require states to have an Income and Eligibility Verification System (IEVS), but states are not required to verify income and assets through the IEVS for every Medicaid recipient and may conduct these verifications after enrollment. Under these systems, state Medicaid agencies use information from a number of federal and state sources to verify financial eligibility, including state wage information maintained by the State Wage Income Collection Agency (SWICA) and information on net earnings from self employment, wages, and retirement benefits maintained by the Social Security Administration (SSA).

### **Look-Back Period for Financial Eligibility**

For evacuees who may have lost their homes and other assets and are now without jobs, will requirements related to the period over which income is examined for the purpose of determining Medicaid eligibility prevent Medicaid funds from being used to meet their needs? Here again, federal laws and regulations stipulate few rules for the look-back period used to determine an individual's financial eligibility for Medicaid, leaving states with a great deal of flexibility.<sup>2</sup> For many eligibility groups, federal regulations require that states use income counting methods that are no more restrictive than method used under the most closely related cash welfare program.<sup>3</sup> Such methods can be less restrictive at states' option. For certain other groups, such as the medically needy (generally people who become eligible for Medicaid in part because they spend considerable amounts of their income on medical care), the budget period can be no longer than six months. Again, states have the flexibility to shorten such budget accounting periods.

### **People Who Do Not Meet Current Eligibility Requirements**

As previously noted, Medicaid eligibility is limited by two primary types of current law restrictions: financial and categorical. Individuals qualify for Medicaid by having income and assets that fall below certain thresholds and by falling into particular groups or categories of individuals. In general those categories include the elderly, people with disabilities, dependent children, parents of dependent children, and pregnant women. Could exceptions to these categorical restrictions be made for people impacted by the Katrina disaster? Many states have used Section 1115 Medicaid waivers (discussed later in this report) to allow categorical eligibility requirements to be waived. Many states have also exercised options that allow them to liberalize eligibility without the use of a waiver, such as the option to disregard certain amounts of income or assets for particular groups.

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<sup>1</sup> For example, individuals applying for certain Medicaid-covered long-term care services must provide financial records for up to a five-year look-back period. These requirements are outlined in Section 1917(c)(1)(A) of the Social Security Act.

<sup>2</sup> A major exception to this rule is for individuals applying for certain Medicaid-covered long-term care services, in which case up to five years of financial records may be examined.

<sup>3</sup> Traditionally, eligibility for Medicaid was linked to the receipt of cash welfare payments. While this is no longer true for all coverage groups, many income and asset counting rules are still linked to those used under existing or former cash welfare programs.

# Medicaid Benefits

## Background

Medicaid's basic benefit rules require all states to provide certain mandatory services listed in federal statute. Examples of services that are mandatory for most groups of Medicaid recipients include (1) inpatient and outpatient hospital services, (2) federally qualified health center (FQHC) services, (3) lab and X-ray services, (4) physician services, (5) certain nurse practitioner services, (6) pregnancy-related services (including postpartum care), (7) early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21, (8) nursing facility care for persons age 21 and over, and (9) home health care for persons entitled to nursing facility care.

The statute also lists additional services that are considered optional—that is, available to recipients if states choose to include them in their state Medicaid plans. Some of these optional benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined as classes of medical providers whose array of services are considered to be Medicaid covered benefits (e.g., psychologists, nursing facility care for persons under age 21, intermediate care facility services for individuals with mental retardation (ICFs/MR)). Still others include a wide range of types of medical care and services (e.g., physical therapy, prescribed drugs, personal care services, private duty nursing, hospice, clinic services, and rehabilitation).

In addition to the above general rules regarding mandatory and optional benefits, Medicaid statute specifies special benefits or special rules regarding certain benefits for targeted groups of individuals. For example, for children under the age of 21, EPSDT guarantees access to all federally coverable services that are necessary to correct or ameliorate identified defects, physical and mental illnesses, and other conditions. States are required to provide otherwise optional services to a Medicaid child, even if that service is not listed in the state Medicaid plan. Thus, children in any state can receive eyeglasses through Medicaid, for example, while adults living in the same state may not have any, or limited, access to this optional benefit.

Medicaid is also an important financing mechanism for long-term care (LTC). LTC services refer to a wide range of supportive and health services generally provided on an ongoing basis for persons who have limitations in functioning because of a disability or chronic condition. Medicaid-covered nursing facility (NF) and ICF/MR services are generally categorized as “institutional” services because individuals reside in and receive health care services in a specific type of certified facility. Other Medicaid-covered LTC services (e.g., personal care, home health care) are categorized as “home and community-based” care because individuals generally receive these services in the community (e.g., in their homes or apartments).

States also have the option of requesting permission from the federal government to provide other home and community-based services for individuals who would otherwise need the level of care in an institution. These other services may be offered as a supplement to, or instead of, those optional services available through the state plan. This option is referred to as a Home and Community-Based Services (HCBS) waiver, authorized under Section 1915(c) of the Social Security Act. Unlike services offered as part of the state Medicaid plan, the HCBS waiver allows states to limit the number of individuals served and to offer the services on a less-than-statewide basis. These waivers include a broad range of services such as case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, home modifications, and home-delivered meals.



## Issues Raised by Hurricane Katrina

### Variation in Benefit Coverage Across States

Because each state designs and administers its own Medicaid program under broad federal rules, coverage of benefits varies from state to state. Among the five states initially declared to have public health emergencies due to Hurricane Katrina (Alabama, Florida, Louisiana, Mississippi, and Texas), certain optional services<sup>4</sup> are covered in all of these states (e.g., hospice care, ICF/MR, prescribed drugs, prosthetic devices, and transportation). Other optional services are not covered by all of these states (e.g., physical therapy, emergency hospital services in non-certified hospitals,<sup>5</sup> care for the elderly in institutions for mental disease (IMD), eyeglasses, and basic dental care).

In addition to choosing the menu of optional services they will provide, states define the specific parameters (e.g., amount, duration and scope) of each mandatory and optional service covered under the state Medicaid plan within broad federal guidelines. Thus, even for mandatory benefits, there will be variations in the breadth of coverage from state to state.

There has been discussion about the potentially substantial mental health needs of survivors of Hurricane Katrina in both home and host states.<sup>6</sup> A wide range of inpatient and outpatient mental health services may be provided through several mandatory and optional benefits under Medicaid. However, even among states that cover a specific benefit (e.g., psychologist services, services in mental health clinics, other mental health rehabilitation and stabilization services), there may be interstate variations in the amount, duration and scope of such covered benefits.

In the wake of Hurricane Katrina, questions have been raised about which state's benefit package will apply to individuals who have been displaced from their home state. For example, if a 16-year-old Medicaid recipient from Louisiana relocates to Texas because of Hurricane Katrina and needs inpatient psychiatric services, will he be able to obtain this care given that the Texas Medicaid program does not cover this benefit while Louisiana's Medicaid program does?<sup>7</sup>

The answer to this question is currently unclear. As discussed in the Payment and Financing section of this report, if a Medicaid recipient is evacuated to another state, the home state is obligated under certain circumstances to pay for covered services (i.e., covered by the home state) that are provided out-of-state. However, the Medicaid recipient must find a provider who is willing to accept the home state's Medicaid coverage, which may be difficult. As discussed earlier in the Medicaid Eligibility and Access section of this report, there is also a residency question for people who have been displaced. If a Medicaid recipient or any other individual has no intention of returning to their home state, will they now be considered a resident of their host

<sup>4</sup> Information on benefit coverage is taken from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid At-A-Glance 2003*, Publication No. CMS-11024-03. (Hereafter cited as CMS, *Medicaid At-A-Glance 2003*.) These data are based on a review of approved state Medicaid plans and waivers as of September 30, 2003.

<sup>5</sup> Includes care that is necessary to prevent the death or serious impairment of the health of a recipient, and because of the threat to life or health necessitates the use of the most accessible hospital that is equipped to provide these services, even if that hospital does not meet the conditions of participation in Medicare, or the definition of mandatory inpatient and outpatient services under Medicaid.

<sup>6</sup> For example, HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded \$600,000 in emergency grants to four states to meet mental health assessment and crisis counseling needs. See [http://www.samhsa.gov/news/newsreleases/050913\\_hhs.htm](http://www.samhsa.gov/news/newsreleases/050913_hhs.htm).

<sup>7</sup> CMS, *Medicaid At-A-Glance 2003*.



state—which may offer a different benefit package than their home state—for Medicaid purposes?

### **Access to Long-Term Care Services**

Individuals eligible for Medicaid-covered LTC services generally have significant physical or mental impairments that often require 24-hour supervision and assistance with activities of daily living (e.g., eating and drinking, using the toilet, getting in and out of bed). Medicaid covers long-term care services in both institutional (e.g., nursing homes and ICFs/MR) and home and community-based settings (e.g., home care, adult day care, transportation, personal attendant care) for certain individuals. Because LTC recipients are highly dependent upon paid direct care staff (also referred to as paraprofessionals), such as certified nursing assistants in nursing homes and home health aides providing a range of services to beneficiaries in their homes, access to such care will be critical in the locations to which these individuals are evacuated.

Unfortunately, many states are experiencing difficulties in attracting and retaining a sufficient supply of paraprofessionals to meet the growing demand for long-term care services in all settings, even in the absence of a disaster such as Hurricane Katrina. Furthermore, many Medicaid beneficiaries with long-term care needs obtain assistance from unpaid caregivers, such as spouses, relatives, or neighbors. Such assistance often enables these individuals to remain at home or in a community setting, helping to reduce reliance on Medicaid-covered LTC institutions. The death or displacement of paid and unpaid caregivers may lead more evacuees to go without needed assistance or to seek services from Medicaid-covered institutions in both home and host states, further straining staff-to-resident ratios in institutions.

Another factor to consider is the impact on access to home and community-based services posed by the movement of HCBS waiver recipients across states. It remains unclear whether persons enrolled in HCBS waivers in their home states will be able to enroll in similar waiver programs in their host states. First, enrollment in waiver programs is dependent upon a person having access to housing in the community. It is unclear whether community-based housing will be available to evacuees with long-term care needs. Second, many states already have waiting lists for waiver enrollment slots. As a result, host states might request federal approval to lift their enrollment caps to cover evacuees and may need to renegotiate cost neutrality agreements with the Secretary.<sup>8</sup> Third, each HCBS waiver covers a different set of services and is targeted toward a distinct population. As a result, persons eligible for waiver services in their home state may find that they are either ineligible for waiver services in their host state or that the services offered do not meet their needs. If no appropriate community-based alternatives are available, will these evacuees then be placed in host state institutions?

### **Cost-Sharing**

Finally, while cost-sharing is not widely applied under Medicaid, state policies may also be an issue for Hurricane Katrina survivors who remain in their home states as well as those that relocate to other states. This issue is particularly relevant to some of the working people with disabilities who pay substantial premiums for Medicaid coverage. Will home states continue to require cost-sharing for in-state evacuees? Will host states require out-of-state evacuees to

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<sup>8</sup> Section 1915(c) of the Social Security Act constrains states to a budget neutrality test in defining which services they cover under the HCBS waiver program. Specifically, the statute requires that the average per capita Medicaid expenditures estimated by the state in any fiscal year for waiver enrollees can not exceed the amount Medicaid would have paid if the individuals were residing in an institution.

comply with participation and point-of-service cost-sharing requirements applicable to in-state Medicaid recipients? Or will the home state cost-sharing requirements, if any, apply instead?

## **Payment and Financing**

### **Background**

The Medicaid program is jointly financed by the federal government and the states. States incur Medicaid expenditures by reimbursing providers for the covered care and services they provide to Medicaid recipients and by administering their Medicaid programs (e.g., conducting eligibility determinations, processing claims, enrolling providers) in compliance with federal requirements. Each quarter, states submit accounting statements detailing their Medicaid expenditures to the federal government and are reimbursed at the applicable federal rate.

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

### **Issues Raised by Hurricane Katrina**

#### **Increased Costs Resulting from Increased Enrollment**

States affected by Hurricane Katrina—including both those that have taken in large numbers of individuals displaced by it and those whose own population may be struggling financially in the aftermath—are concerned about the possibility of a surge in Medicaid program enrollment, and some advocate that enhanced federal reimbursement should be made available for Medicaid costs associated with serving hurricane victims. A legislative change may be required to provide such enhanced reimbursement, because the Secretary of HHS does not have the authority to waive provisions of federal Medicaid law that govern payments to states via the FMAP and other federal Medicaid reimbursement rates (e.g., those that apply to administrative functions).<sup>9</sup>

As described above, the FMAP is used to reimburse states for most of their Medicaid service expenditures. Current statutory exceptions to the FMAP include family planning services and supplies (reimbursed at 90%), services that are received through an Indian Health Service (IHS) facility (reimbursed at 100%), and services provided to targeted low-income children enrolled in Medicaid who qualify through State Children's Health Insurance Program (SCHIP) provisions (reimbursed at an enhanced FMAP that varies by state and may range from 65% to 85%, subject to the availability of funds from a state's federal SCHIP allotment).

In addition to experiencing an increase in expenditures for medical care, states may also see an increase in administrative costs associated with performing eligibility determinations for hurricane victims. In the past, temporary increases in federal reimbursement (separate from the permanent enhancements available for specified administrative functions, such as the 100% reimbursement provided for operating an immigration status verification system) have been

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<sup>9</sup> Section 1903 of the Social Security Act governs payments to states for Medicaid. See the discussion of federal waiver authority later in this report for more information on provisions of Medicaid law that can and cannot be waived administratively.

authorized by Congress to assist states with administrative costs. For example, a \$500 million federal fund was made available beginning in 1997 (and continuing until exhausted) to provide states with enhanced federal reimbursement for administrative expenditures attributable to eligibility determinations that would not have been made were it not for the implementation of the Temporary Assistance for Needy Families (TANF) program.<sup>10</sup>

### **Payments for Out-of-State Care**

Under federal law, regulations promulgated by the Secretary of HHS dictate the extent to which states must furnish Medicaid assistance to state residents who are absent from the state.<sup>11</sup> Under these regulations, a state must pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the state and any of the following conditions is met:

- medical services are needed because of a medical emergency;
- medical services are needed and the recipient's health would be endangered if he were required to travel to his state of residence;
- the state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
- it is general practice for recipients in a particular locality to use medical resources in another state.

The regulations also require states to establish procedures to facilitate the furnishing of medical services to individuals who are present in one state but eligible for Medicaid in another. In cases where a Medicaid recipient seeks out-of-state care not related to a medical emergency, the home state may typically require prior authorization of the care. The home state may also require the out-of-state provider to enroll or otherwise enter into an agreement with its Medicaid program as a condition of receiving payment. In the case of bordering states where recipients commonly cross state lines to seek care, states often have agreements in place to facilitate the provision and payment of Medicaid services.

For Medicaid recipients who were displaced from their home state by Hurricane Katrina, nothing under federal law would prevent the home state from paying for all covered services (i.e., covered under the home state's Medicaid program) that are provided to recipients while they are in another state. At minimum, the home state must pay if any of the conditions listed above are met. However, the Medicaid recipient must find an out-of-state provider willing to accept Medicaid payment from the home state, and not all providers may be willing to do so.<sup>12</sup> In addition, since an individual may be considered a resident of the state to which they have evacuated, he or she may be subject to the eligibility rules of that state's Medicaid program (see the Medicaid Eligibility and Access section of this report for more information on residency).

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<sup>10</sup> Section 1931(h) of the Social Security Act.

<sup>11</sup> Section 1902(a)(16) of the Social Security Act and 42 CFR 431.52.

<sup>12</sup> For example, Barbara Coulter Edwards, the Ohio Medicaid director, has reportedly indicated that her agency had received calls from hurricane victims who had found shelter in Ohio but were turned away by health care providers unwilling to accept out-of-state Medicaid cards. See

<http://www.nytimes.com/2005/09/07/national/nationalspecial/06cnd-welfare.html?ei=5070&en=247ac2ca27b8a7be&ex=1126756800&adxnnl=1&emc=eta1&adxnnlx=1126181605-mqKqPzFajORBtyFxJXs0/g>.

## State and Federal Responses

States operate their Medicaid programs in the context of federal rules. While some of these rules are flexible enough to allow states to act without federal intervention in the wake of Hurricane Katrina, certain issues raised by the disaster may be addressed only through administrative or legislative action by the federal government.

For example, although states have a great deal of flexibility in setting eligibility and benefit rules, they are generally required to apply these rules equally to all applicants and recipients to ensure that they meet federal Medicaid requirements governing statewideness and comparability of benefits. If a state wants to modify these rules substantially (e.g., by allowing coverage of childless adults who ordinarily could not qualify for Medicaid) or apply special rules to a select group of individuals (e.g., allowing Medicaid coverage for all hurricane victims who meet categorical eligibility requirements by disregarding their income), federal permission in the form of a waiver granted by the Secretary of HHS would generally be required.

Although states are not obligated to participate in the Section 1115 waiver arrangement being offered by the federal government in response to Hurricane Katrina (described later in this report), several have opted to do so. As discussed earlier, congressional action may be required if enhanced reimbursement is to be provided to states for Medicaid costs incurred as a result of Hurricane Katrina. Congress may also wish to consider the desirability of uniform treatment of hurricane victims across states.

## Recent State Actions

A number of states have expressed a desire for explicit federal guidance on Medicaid issues raised by Hurricane Katrina.<sup>13</sup> Although the situation is evolving at the federal level both administratively and legislatively, examples of state actions reported thus far include the following:<sup>14</sup>

- In the wake of the storm, Louisiana began providing temporary Medicaid cards to Medicaid recipients who lost their cards in the hurricane and allowing recipients who have left their homes because of Hurricane Katrina to access Medicaid services—without any prior authorization requirements—in or out of state from any medical provider that is willing to accept Louisiana Medicaid as payment. An emergency procedure was put in place to expedite provider enrollment for purposes of receiving Medicaid payment, and the state was making Medicaid staff members available at the Family Assistance Centers being set up by the Federal Emergency Management Agency (FEMA) and at many shelters across the state to help those affected by Hurricane Katrina fill out forms to get health coverage. Because of the severe statewide impact of Hurricane Katrina, all of Louisiana Medicaid's staff is being called upon to sign up those who have been devastated by the hurricane and need health coverage, and all people who currently have coverage through the state's SCHIP or Medicaid

<sup>13</sup> For example, see Kaiser Commission on Medicaid and the Uninsured, *Reporter Teleconference Briefing on Health Coverage After Katrina* (Sept. 9, 2005), available at <http://www.kff.org/medicaid/kcmu090905pkg.cfm>.

<sup>14</sup> Also see American Public Human Services Association, *News on State and Local Relief Efforts*, available at <http://www.aphsa.org/katrina/news/default.asp>.

program will have their renewal dates extended by six months.<sup>15</sup> Louisiana also requested permission from CMS to cancel as yet unpaid premiums for individuals enrolled in a buy-in program for working persons with disabilities through December 2005. In response, CMS has granted a waiver of these premium payments for 120 days.<sup>16</sup> Currently, the state has a “Hurricane Katrina Medicaid Program” to help people affected by the storm by offering them temporary no-cost health coverage. Although the state indicates that this program is not an expansion of Medicaid, the following are differences between Hurricane Katrina Medicaid and regular Medicaid in Louisiana: coverage is temporary, coverage will not be renewed, self-declaration of disability is accepted, self-declaration of income is accepted, and only people from affected areas can apply.<sup>17</sup>

- The Mississippi Division of Medicaid is encouraging its medical providers and pharmacies to provide essential services for Medicaid recipients who have migrated from Louisiana as well as other parts of Mississippi. An emergency enrollment form that allows for temporary (120-day) provider enrollment in the state’s Medicaid program is available. Providers may call a toll-free number to verify an individual’s eligibility for Mississippi Medicaid.<sup>18</sup> As described later in this report, the state recently obtained a Hurricane Katrina Section 1115 waiver that provides up to five months of temporary coverage for certain evacuees from emergency areas.
- In Alabama, the Governor signed a proclamation expediting the process of obtaining prescription drug refills for storm victims and announcing that people could go to any pharmacy and receive assistance with their medications (there is no mention of how these services would be financed).<sup>19</sup> The state is allowing out-of-state providers not enrolled in its Medicaid program the ability to verify eligibility for Alabama Medicaid recipients via its Automated Voice Response System (AVRS), and a special expedited enrollment process has been developed for out-of-state providers furnishing medical services to Alabama Medicaid recipients.<sup>20</sup> As described later in this report, the state recently obtained a Hurricane Katrina Section 1115 waiver that provides up to five months of temporary coverage for certain evacuees from emergency areas.
- Following the hurricane, the Texas Health and Human Services Commission provided Texas pharmacies and providers with information on how to assist Louisiana, Mississippi and Alabama residents who are on Medicaid and need to

<sup>15</sup> Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, *Louisiana Medicaid Response to Hurricane Katrina*, available at <http://www.dhh.louisiana.gov/offices/page.asp?id=92&detail=5156>.

<sup>16</sup> American Public Human Services Association, *Updated Information on Hurricane Katrina Disaster Policies and Assistance* (Sept. 9, 2005), available at <http://www.aphsa.org/katrina/disasterpolicy9-9-05.asp>.

<sup>17</sup> Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, *Hurricane Katrina Louisiana Medicaid Program*, available at <http://www.dhh.louisiana.gov/offices/?ID=180>.

<sup>18</sup> Mississippi Division of Medicaid, *Provision of Essential Services to Medicaid Beneficiaries Displaced by Hurricane Katrina*, available at [http://www.dom.state.ms.us/Emergency\\_Provisions\\_Due\\_To\\_Katrina.pdf](http://www.dom.state.ms.us/Emergency_Provisions_Due_To_Katrina.pdf).

<sup>19</sup> Alabama Department of Public Health, *Alabama’s health care services are not interrupted by Hurricane Katrina* (Sept. 6, 2005), available at <http://www.adph.org/NEWSRELEASES/default.asp?TemplateNbr=0&DeptID=107&TemplateId=3914>.

<sup>20</sup> Alabama Medicaid Agency, *Hurricane Katrina Update*, available at [http://www.medicaid.state.al.us/news/hurricane\\_update.aspx?tab=2](http://www.medicaid.state.al.us/news/hurricane_update.aspx?tab=2).

fill prescriptions or obtain other services in Texas. In addition, the Texas Department of State Health Services was assessing long and short-term medical care needs and other special arrangements for evacuees who are hospital patients, medically fragile, injured, ill or have other special needs.<sup>21</sup> As described later in this report, the state recently obtained a Hurricane Katrina Section 1115 waiver that provides up to five months of temporary coverage for certain evacuees from emergency areas.

## Federal Waiver Authority

### Section 1115 Waiver Authority

Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects under several programs authorized in the Social Security Act. Specifically, Section 1115 authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (SCHIP). Under Section 1115, the Secretary may waive any Medicaid requirements contained in Section 1902 (including but not limited to what is known as “freedom of choice” of provider, “comparability,” and “statewideness”).<sup>22</sup> States must submit proposals outlining terms and conditions for proposed waivers to CMS for approval before implementing these programs. Whether large or small reforms, Section 1115 waiver programs have resulted in significant changes for Medicaid recipients nationwide, and serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from the devastation of a natural or other disaster.

In recent years, there has been increased interest among states and the federal government in the Section 1115 waiver authority as a means to restructure Medicaid coverage, control costs, and increase state flexibility. Under current law, states may obtain waivers that allow them to provide services to individuals not traditionally eligible for Medicaid, cover non-Medicaid services, limit benefit packages for certain groups, adapt their programs to the special needs of particular geographic areas or groups of recipients, or accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster, among other purposes.

Following the September 11, 2001 terrorist attacks, for example, New York requested and received approval for a Section 1115 waiver known as “Disaster Relief Medicaid” (DRM). The DRM program allowed Medicaid applicants who were residents of New York City to receive four months of coverage if they met the eligibility requirements of the Medicaid or Family Health Plus program, and they applied for DRM between September 11, 2001, and January 31, 2002 (for more detail on this temporary waiver program see discussion below).

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law

<sup>21</sup> State of Texas, Office of the Governor, *Gov. Perry Seeks Assurance of Full Reimbursement of Health Care Expenses* (Sept. 7, 2005), available at <http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2005-09-08.5610>.

<sup>22</sup> “Freedom of choice” refers to a requirement that Medicaid recipients have the freedom to choose their medical care providers. “Comparability” refers to a requirement that services be comparable in amount, duration, and scope for all persons in each eligibility group. “Statewideness” refers to the requirement that states provide services on a state-wide basis, rather than in only a portion of the state. For SCHIP, no specific sections or requirements are cited as “waivable.” Section 2107(e)(2)(A) of SCHIP statute simply states that Section 1115 of the Social Security Act, pertaining to research and demonstration waivers, applies to Title XXI.



and regulations specify limitations or restrictions on how a state may operate a waiver program. For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing imposed under Section 1115 waivers. Other features of the Section 1115 waiver authority that may be relevant in using this authority to respond to disasters include:

- *Federal Reimbursement for Section 1115 Demonstrations.* Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan for purposes of federal reimbursement. Project costs associated with waiver programs are subject to that state's FMAP.<sup>23</sup> Changes to these financing arrangements, even under a Section 1115 waiver, would require congressional action.
- *Financing and Budget Neutrality.* Unlike regular Medicaid, CMS waiver guidance specifies that costs associated with waiver programs must be *budget neutral* to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law program requirements. An exception to this guidance on budget neutrality was made by the Secretary for the Section 1115 waiver granted to New York after September 11, 2001. CMS approved an allotment neutrality test (described below) for New York's Disaster Relief Medicaid Section 1115 waiver program. By contrast, the Secretary eliminated all tests of budget *and* allotment neutrality in the recent approvals of Section 1115 emergency Medicaid waivers.
- *Financing and Allotment Neutrality.* Under the SCHIP program, a different budget neutrality standard applies. States must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program *and* for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels. Any additional financial resources for SCHIP would require congressional action.
- *Relationship of Medicaid/SCHIP Demonstration Waivers to Other Statutes.* Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer-sponsored health insurance as described by the Employee Retirement Income Security Act (ERISA), or alien eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive provisions in these other statutes.<sup>24</sup>
- *Program Guidance.* The Secretary can develop policies that influence the content of demonstration projects and prescribe approval criteria in three ways: (1) by promulgating program rules and regulations;<sup>25</sup> (2) through the publication of

<sup>23</sup> Section 1903 describes the conditions under which federal financial participation is available. Section 1115(a)(2) stipulates that expenditures under a waiver are eligible for matching under Section 1903. The same federal reimbursement rules apply to SCHIP waiver projects. As with SCHIP state plan expenditures, SCHIP Section 1115 waiver programs are reimbursed at an enhanced federal matching rate.

<sup>24</sup> For example, states may not provide benefits to qualified aliens as a part of a Section 1115 eligibility expansion without adhering to the five-year ban on alien access to federal assistance as required by the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193).

<sup>25</sup> Program rules and regulations that meet specified rulemaking criteria are legally binding. To date, CMS has *not*



program guidance (e.g., the waiver program must meet a budget neutrality test);<sup>26</sup> and (3) waiver policy may also be implicitly shaped by the programs that have been approved (e.g., CMS approval of New York's "Disaster Relief Medicaid"). Legislative action may be required if Congress chooses to further shape the Secretary's authority over the content of the demonstration programs, dictate specific Section 1115 waiver approval criteria, or otherwise limit the Secretary's waiver authority.

### **Precedent for Emergency-Related Section 1115 Waivers: New York's Disaster Relief Medicaid Program**

Federal and state officials have looked to New York's Section 1115 Disaster Relief Medicaid program as precedent for the Secretary of HHS to use the authority under Section 1115 of the Social Security Act to respond to emergency situations. Details on eligibility criteria, benefit packages, provider agreements, financing arrangements, and other issues outlined in the terms and conditions of New York's temporary waiver program provide an example of how this state used the flexibility under Section 1115 to address specific health care needs in the wake of an emergency situation.

Following the terrorist attacks on September 11, 2001, New York requested and received approval for a Section 1115 waiver known as "Disaster Relief Medicaid." The DRM program allowed most Medicaid applicants who were residents of New York City to receive four months of coverage if they met the eligibility requirements of the Medicaid or Family Health Plus (FHP) program, and they applied for DRM between September 11, 2001, and January 31, 2002. The FHP program is a separate Section 1115 waiver that had been approved by CMS, and was scheduled to be implemented in October 2001. FHP significantly expanded Medicaid eligibility to certain groups; for example, the income standard for childless adults went from about 50% to 100% of the federal poverty level.<sup>27</sup>

Medicaid applicants who did not receive coverage under the DRM program included those who were pregnant, had a disability, or required institutional services (e.g., nursing facility). These individuals were processed through the traditional Medicaid application process.<sup>28</sup> This separate process for certain groups is not described in a February 2003 lawsuit which states that the DRM program was the only Medicaid program available to New York City Medicaid applicants between September 2001 and January 2002.<sup>29</sup>

The DRM program also extended eligibility for current Medicaid beneficiaries residing in New York City and Westchester County who were scheduled to have their Medicaid eligibility annual

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shaped Section 1115 waiver-related policy through program rules and regulations.

<sup>26</sup> Unlike program rules and regulations, program guidance is not legally binding. Rather, program guidance provides a framework for the process by which states may obtain approvals and the principles under which states may operate their programs. Program guidance contains authoritative interpretation and clarification of statutory and regulatory requirements. To date the Secretary only used guidance through public notices in the *Federal Register*, as well as technical guidance distributed to state health officials and HHS regional officers or posted on the CMS website to shape Section 1115 waiver policy.

<sup>27</sup> K. Haslanger, "Radical Simplification: Disaster Relief Medicaid in New York City," *Health Affairs*, Jan./Feb. 2003.

<sup>28</sup> Personal communication with Betty Rice, Director, Division of Community and Local District Relations, New York Department of Health. (Hereafter cited as "Personal communication, B. Rice.")

<sup>29</sup> *Olson v. Wing*, U.S. District Court for the Eastern District of New York (Feb. 14, 2003).

re-certification. These individuals were permitted to receive coverage for one year without the annual re-certification normally required by Medicaid law.<sup>30</sup>

The waiver also included temporary eligibility for children under SCHIP if they had applied or were enrolled with health plans that had operations in New York City that were disrupted by the World Trade Center attacks. New SCHIP applicants received four months of SCHIP eligibility, and individuals who were already in a period of presumptive eligibility that was scheduled to end September 30, 2001, received an additional two months of eligibility. Similar to the Medicaid provisions above, SCHIP enrollees in New York City who were scheduled to have an annual re-certification were allowed to continue with SCHIP coverage for one year.

The Secretary of HHS announced tentative approval of the DRM program in a September 19, 2001 press release. Approval of the temporary modifications to New York's SCHIP program were provided via e-mail and through discussions with senior staff at CMS. On September 16, 2002, CMS articulated the agreement with New York in an award letter and terms and conditions. CMS awarded final approval for the DRM Section 1115 waiver on December 31, 2002. CMS decided not to apply its usual Medicaid cost neutrality requirements (described earlier) to the waiver because of the unusual circumstances of September 11, 2001. However, the SCHIP allotment neutrality requirements did apply.<sup>31</sup>

The September 11 attacks significantly hampered the state Medicaid agency's ability to process Medicaid eligibility records in New York City. The presumptive eligibility process established by the DRM program was intended to facilitate enrollment of new applicants into Medicaid. Applicants for the DRM program were required to fill out a one-page application for the program, prove who they were, and attest to their income and resources. Individuals did not have to be direct victims of the World Trade Center attacks to receive services.

Individuals who qualified for the DRM program received a temporary Medicaid authorization form that allowed them to access Medicaid services. Services provided under the DRM program included all fee-for-service benefits provided to non-institutionalized Medicaid beneficiaries.

In addition to the four months of additional coverage, it also allowed individuals several additional months of eligibility to provide sufficient time for an individual to complete a standard Medicaid application form.<sup>32</sup> The waiver ended in January 2003.

If a person was denied Medicaid coverage at the end of the DRM period, under the New York waiver DRM recipients were not entitled to continuation of DRM benefits while their request for a fair hearing was pending. A suit was brought by DRM recipients alleging that the lack of continuing Medicaid benefits constituted a violation of the Due Process Clause of the United States Constitution. The U.S. District Court for the Eastern District of New York issued a preliminary injunction, affirmed by the U.S. Court of Appeals for the 2<sup>nd</sup> Circuit, ordering the New York State Medicaid Agency to continue DRM benefits to all recipients who received a Notice of Decision terminating their benefits until a fair hearing decision was reached. While the court did not decide this case on its merits, it is an indication that while the Secretary has the authority to waive provisions in Section 1902 for a Section 1115 waiver project, the Secretary's authority may be limited by constitutional considerations.

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<sup>30</sup> Centers for Medicare and Medicaid Services, Waiver approval letter to Dr. Antonia Novello, New York State Department of Health (Dec. 31, 2002). (Hereafter cited as "Waiver approval letter.")

<sup>31</sup> Waiver approval letter.

<sup>32</sup> Waiver approval letter.

An estimated 342,000 beneficiaries enrolled in the DRM program, and funding for the DRM waiver was estimated at \$670 million over the waiver period.<sup>33</sup> Generally, New York receives federal reimbursement for 50% of its Medicaid service expenditures. New York requested that FEMA cover the non-federal share of Medicaid expenditures for the DRM program through the agency's public assistance funds; however, FEMA denied that request. The request is currently under appeal in FEMA.<sup>34</sup>

### **Section 1135 Waiver Authority**

The Section 1135 waiver authority is a second mechanism currently available to allow the Secretary of HHS to make immediate program changes in response to an emergency situation; however, the authority is limited to geographic areas directly impacted by the emergency. Created under the Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188), Section 1135 of the Social Security Act authorizes the Secretary to temporarily waive federal conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP recipients in an emergency area (defined as a geographical area in which there exists an emergency or major disaster declared by the President *and* a public health emergency declared by the Secretary of HHS). During such an emergency, it authorizes the Secretary to waive:

- participation, state licensing (as long as equivalent licensure from another state is held and there is no exclusion from practicing in that state or any state in the emergency area), and pre-approval requirements for physicians and other practitioners;
- sanctions for failing to meet requirements for emergency transfers between hospitals;
- sanctions for physician self-referral; and
- limitations on payments for health care and services furnished to individuals enrolled in Medicare Advantage (MA) plans when services are provided outside the plan.

In addition, Section 1135 requires the Secretary to provide Congress with certification and written notice at least two days prior to exercising this waiver authority. It provides for the waiver authority to continue for 60 days, and permits the Secretary to extend the waiver period. Finally, the law requires the Secretary, within one year after the end of the emergency, to provide Congress with an evaluation of this approach and recommendations for improvements under this waiver authority.

### **Current Waiver Activity Related to Hurricane Katrina**

The Secretary of HHS has exercised both the Section 1115 waiver authority and the Section 1135 waiver authority to make needed changes to health care programs so they are better able to accommodate the emergency health care needs of Hurricane Katrina survivors. Below is a brief description of the information that is currently available regarding each of these waiver actions.

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<sup>33</sup> Personal communication, B. Rice.

<sup>34</sup> Personal communication with Emil Slane, New York Division of the Budget.

## Section 1115 Waivers

On September 9, 2005, CMS announced emergency policies that it had adopted to address the health care needs of Hurricane Katrina survivors.<sup>35</sup> Specifically, CMS noted that President Bush had announced that “special evacuee status” would be granted to individuals impacted by Hurricane Katrina and that evacuees would be allowed to apply for several federal programs, including Medicaid and SCHIP, without having to verify their income or employment status. CMS also noted that an application template was being developed to assist states in obtaining emergency Medicaid and SCHIP Section 1115 waivers to provide temporary eligibility for evacuees.

On September 15, 2005, Texas became the first of 17 states to obtain approval for a Section 1115 waiver based on the emergency application template developed by CMS (these waivers are referred to as being part of a multi-state demonstration project). To date, similar waivers have also been approved for Alabama, Arkansas, California, the District of Columbia, Florida, Georgia, Idaho, Indiana, Louisiana, Maryland, Mississippi, Nevada, Ohio, Puerto Rico, South Carolina, and Tennessee.<sup>36</sup>

All of the waivers granted thus far create a temporary eligibility period, not to exceed five months,<sup>37</sup> during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP state plan<sup>38</sup> services in the host state (i.e., the state that has been granted an emergency Section 1115 waiver) based on simplified eligibility criteria for various groups (children and their parents, pregnant women, individuals with disabilities, etc.). Under the Alabama, District of Columbia, Idaho, Louisiana, Nevada, Puerto Rico, and Texas waivers, evacuees are exempt from Medicaid and SCHIP cost-sharing requirements. Medicaid and SCHIP cost sharing requirements will be imposed under the remaining waiver programs in each of Arkansas, California, Florida, Indiana, Georgia, Maryland, Ohio, South Carolina, Tennessee, and Mississippi.<sup>39</sup>

In addition to creating temporary eligibility for evacuees under the host state’s Medicaid or SCHIP state plan, waivers for eight out of the 17 states (Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas) also create an uncompensated care pool. In seven of the eight states whose waivers create an uncompensated care pool (Alabama, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas), the pool may be used (through January 31, 2006) to augment Medicaid and SCHIP state plan services for evacuees (e.g., provide

<sup>35</sup> Centers for Medicare and Medicaid Services, *CMS Takes Emergency Steps to Ease Health Care Access to Katrina Evacuees* (Sept. 9, 2005), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1551>.

<sup>36</sup> Centers for Medicare and Medicaid Services, *Approved Katrina 1115 Waiver Documents*, available at [http://new.cms.hhs.gov/Emergency/02\\_Hurricanes.asp](http://new.cms.hhs.gov/Emergency/02_Hurricanes.asp).

<sup>37</sup> The duration of Ohio’s Hurricane Katrina Relief waiver program is unique in that the program will operate for the four-month period between September 1, 2005 and December 31, 2005. All of the other emergency waiver programs will operate for the five-month period between September 1, 2005 and January 31, 2006.

<sup>38</sup> In order for a state to receive federal Medicaid (or SCHIP) reimbursement, it must have in effect a Medicaid (or SCHIP) state plan approved by the Secretary of HHS that meets requirements set forth in federal statute and regulations. If a state wants to change how its program operates (e.g., by adjusting eligibility levels or benefit coverage) or if Congress modifies a requirement (e.g., adds a new mandatory eligibility group), the state must submit for approval a state plan amendment describing the change. As described earlier, Section 1115 waivers, which allow states to operate their Medicaid and SCHIP programs outside of normal federal rules, are deemed to be part of the Medicaid (or SCHIP) state plan for purposes of federal reimbursement.

<sup>39</sup> Providers will be responsible for collecting beneficiary cost sharing under the Florida, Georgia, Indiana, Maryland, South Carolina, and Tennessee emergency waiver programs.

services not covered under the state plan) and pay for HCBS waiver services not otherwise covered in the host state.<sup>40</sup> In all eight of the states whose waivers create an uncompensated care pool, funds from the pool may be used to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP in the host state. States with an uncompensated care pool must consider alternative methods for providing coverage to uninsured evacuees (including through premium assistance for private insurance and other insurance pools) and report to CMS on the feasibility of adopting such alternative methods.

In general, the Section 1115 waivers define an evacuee as an individual who: (1) is a resident of an emergency area (defined as a geographic area or region in which the President has declared a disaster following Hurricane Katrina, specifically targeting counties and parishes designated by FEMA as requiring individual assistance); (2) has been displaced from his or her home by the emergency; (3) is not considered a non-qualified alien; (4) meets the definition of the new temporary eligibility population. The new temporary eligibility population includes:

- Children under age 19 with income up to and including 200% FPL;
- Pregnant women from Louisiana and Mississippi with income up to and including 185% FPL;
- Pregnant women from Alabama with income up to and including 133% FPL;
- Individuals with disabilities with income up to and including 300% of the Supplemental Security Income (SSI) benefit rate;
- Low-income Medicare recipients with income up to and including 100% FPL;
- Low-income individuals in need of long-term care with income up to and including 300% SSI; and
- Low-income parents of children under age 19 with family income up to and including 100% FPL.

For the purposes of determining waiver program eligibility, evacuees may self-attest to displacement, income, and immigration status, but individuals must cooperate in demonstrating evacuee and eligibility status.

The waiver documents note that the standard Medicaid and SCHIP funding process will be used during the waiver period. However, states will not be required to meet Medicaid budget or SCHIP allotment neutrality tests under the waivers. HHS justified dropping the neutrality requirements because, CMS officials argue, individuals participating in the waiver are presumed to be eligible for Medicaid or SCHIP in their respective home states, and therefore costs to the federal government would have otherwise been incurred and allowable. It is unclear how this argument applies in the case of states whose waivers establish an uncompensated care pool that may be used to pay for costs associated with uninsured evacuees who otherwise do not qualify for Medicaid or SCHIP.<sup>41</sup>

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<sup>40</sup> Costs of services provided to evacuees will not be counted against any other Section 1115 and 1915(b) or (c) waivers the state may have, including HCBS waiver slots.

<sup>41</sup> There is precedent among existing statewide demonstration waivers to expand health insurance to new groups of uninsured individuals within the confines of the budget neutrality requirement. For example, in past waiver approvals CMS allowed states to achieve savings to meet their budget neutrality test by redirecting Medicaid disproportionate share hospital (DSH) payments (which are used to compensate hospitals for the cost of treating uninsured individuals) to cover the costs of expansion eligibles under the waiver demonstration project. Massachusetts' MassHealth demonstration is an example of a state that generated cost savings in this way.



For Section 1115 demonstration waivers, budget neutrality has meant that demonstration projects do not increase federal spending over what would have been spent under current law program requirements.<sup>42</sup> For most Section 1115 waivers, the federal and state governments negotiate a budget neutrality spending cap, beyond which the federal government has no fiscal responsibility. Because the budget neutrality requirement is a construct of waiver guidance that has been added administratively and is *not* a statutory requirement, the Secretary may decide that it will not apply to a particular waiver.

### *Financing Under the Emergency Medicaid Waivers*

On September 16, 2005, the Director of CMS and Medicaid state officials in each of Louisiana, Mississippi, and Alabama signed a “memorandum of understanding” (MOU) whereby home states agreed to pay the non-federal share of costs for medically necessary treatment provided to evacuees while they are residing in a host state.<sup>43</sup> Subsequently, at least two states with Hurricane Katrina Section 1115 waivers have indicated that they expect to receive 100% federal funding for services provided through the waivers.<sup>44</sup>

While the waiver documents from CMS do not indicate how this would be accomplished, during an October 25, 2005, the Senate Committee on Finance *Hearing to Conduct a Markup to Achieve the Committee’s Budget Reconciliation Instructions to Reduce the Growth of Outlays as Contained in H.Con.Res. 95*, a CMS official stated that waiver expenditures for the uncompensated care pools will be reimbursed with 100% federal funds from the National Disaster Medical System (NDMS) program,<sup>45</sup> and that the NDMS program had \$100 million to spend on this and other qualifying activities. The CMS official also stated that costs associated with all other emergency Medicaid waiver services would be the responsibility of the home state.

In addition, the budget reconciliation conference report [i.e., S. 1932 (H.Rept. 109-362)] contains funds for Hurricane Katrina Medicaid and SCHIP relief. If enacted, the conference agreement would appropriate \$2 billion (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have

<sup>42</sup> “Current law program requirements” may include hypothetical program expansions allowable under current law (e.g., groups of eligibles, services or payments which could have been but were not previously covered or provided) as well as program terminations (e.g., the elimination of a state’s medically needy program).

<sup>43</sup> State of Louisiana, Department of Health and Hospitals, *Letter/Memorandum of Understanding between the Centers for Medicare and Medicaid Services and the Louisiana Division of Medicaid* (Sept. 16, 2005); State of Mississippi, Office of the Governor, Division of Medicaid, *Letter/Memorandum of Understanding between the Centers for Medicare and Medicaid Services and the Mississippi Division of Medicaid* (undated); and Alabama Medicaid Agency, *Letter/Memorandum of Understanding between the Centers of Medicare and Medicaid Services and Alabama Medicaid Agency* (Sept. 16, 2005).

<sup>44</sup> Texas Health and Human Services System, *Key Provisions of Texas Waiver* (Sept. 16, 2005), available at <http://www.hhs.state.tx.us/news/release/TexasHurricaneKatrinaKeyProvisions.pdf>. Florida Agency for Health Care Administration, *AHCA Announces Submission of Waiver to Include Hurricane Evacuees in Florida Medicaid* (Sept. 16, 2005), available at [http://www.fdhc.state.fl.us/Executive/Communications/Press\\_Releases/09\\_16\\_2005.shtml](http://www.fdhc.state.fl.us/Executive/Communications/Press_Releases/09_16_2005.shtml).

<sup>45</sup> The National Disaster Medical System (NDMS) was established in HHS in 1984 to provide medical and ancillary services when a disaster overwhelms local emergency services. NDMS is administered by FEMA in the Department of Homeland Security (DHS) Emergency Preparedness and Response Directorate, and is a partnership of HHS, DHS, the Departments of Defense and Veterans Affairs, state and local governments, and the private sector. NDMS consists of a number of response teams that can deploy to a scene rapidly and set up field operations that are self-sustaining for up to 72 hours, until additional federal support arrives. NDMS also provides for transportation of large numbers of casualties from an impacted site to distant locations for care. For more information on NDMS, see CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister.

provided care to affected individuals or evacuees under a Section 1115 project) for certain costs associated with their disaster relief Medicaid and SCHIP waiver programs. (For more details on this and other legislative action on this issue, see the section titled *Current Federal Legislation* that appears later in this report.)

As discussed earlier, the Secretary of HHS does not have the authority to waive provisions of federal Medicaid law governing the FMAP and other federal Medicaid reimbursement rates (e.g., those that apply to administrative functions) under Section 1903 of the Social Security Act, and each state is responsible for paying the non-federal share of any Medicaid costs it incurs.<sup>46</sup> If NDMS funds—and, if enacted, funds made available through the budget reconciliation conference agreement—are insufficient to cover the costs associated with state claims submitted under the uncompensated care pools—it is unclear whether additional steps may be taken by the Secretary to allow the home states to finance their state shares of expenditures for evacuees in other ways.

## Section 1135 Waivers

The Secretary of HHS invoked the Section 1135 waiver authority on each of September 1, September 4, and September 7, 2005, to waive certain requirements and program regulations under Titles XVIII, XIX, and XXI of the Social Security Act to accommodate the emergency health care needs of recipients and medical providers in the Hurricane Katrina-impacted states. **Table 1** shows states that are covered under the Section 1135 waivers authorized by the Secretary of HHS as a result of meeting the following requirements: (1) the President has declared them to be emergency or major disaster areas pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and (2) the Secretary of HHS has declared them to have public health emergencies pursuant to Section 319 of the Public Health Service Act.<sup>47</sup>

**Table 1. States Covered Under Section 1135 Waivers Authorized in Response to Hurricane Katrina**

State	Effective date
States identified in the September 1, 2005 announcement	
Florida	8/24/05
Alabama	8/29/05
Louisiana	8/29/05
Mississippi	8/29/05
States identified in the September 4, 2005 announcement	
Texas	9/2/05
States identified in the September 7, 2005 announcement	

<sup>46</sup> Section 1902(a)(2) of the Social Security Act requires that state funds comprise at least 40% of the non-federal share of Medicaid expenditures. The remaining portion of the non-federal share may be financed with local or other funding sources, subject to other federal requirements (e.g., regarding intergovernmental transfers (IGT), provider taxes and donations, sources of funds that generally may be used to fulfill a state's cost-sharing or matching obligation for a federal grant such as Medicaid, etc.).

<sup>47</sup> For information on the Stafford Act, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea. For information on declarations of public health emergencies, see CRS Report RL33096, *Hurricane Katrina: The Public Health and Medical Response*, by Sarah A. Lister.



State	Effective date
Arkansas	8/29/05
Colorado	8/29/05
Georgia	8/29/05
North Carolina	8/29/05
Oklahoma	8/29/05
Tennessee	8/29/05
West Virginia	8/29/05
Utah	8/29/05

**Source:** U.S. Department of Health and Human Services, *Waiver Under Section 1135 of the Social Security Act* (Sept. 1, 2005); *Waiver Under Section 1135 of the Social Security Act* (Sept. 4, 2005), available at <http://www.hhs.gov/katrina/ssawaiver.html>; *Waiver Under Section 1135 of the Social Security Act* (Sept. 7, 2005), available at <http://www.hhs.gov/emergency/determination2.html>.

In each of the above listed states, the following program operating rules will be loosened under the Section 1135 waiver authority to speed the provision of health care services for individuals enrolled in the Medicare, Medicaid and SCHIP programs, and to ensure that health care providers may be reimbursed for items and services rendered to program recipients:<sup>48</sup>

- Certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.
- The requirement that physicians and other health care professionals hold licenses in the state in which they provide services, if they have a license from another state (and are not affirmatively barred from practice in that state or any state in the emergency area).
- Sanctions under Section 1867 of the act (the Emergency Medical Treatment and Labor Act, or EMTALA) for the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.
- Limitations on payments under Section 1851(I) of the act to permit Medicare Advantage enrollees to use out-of-network providers in an emergency situation.
- Sanctions and penalties arising from noncompliance with the following provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations: (a) the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory (as set forth in 45 CFR 164.510); (b)

<sup>48</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Waiver Under Section 1135 of the Social Security Act* (Sept. 1, 2005). Similar waivers covering additional states were authorized on Sept. 4 and Sept. 7, available at <http://www.hhs.gov/katrina/ssawaiver.html> and <http://www.hhs.gov/emergency/determination2.html>.

the requirement to distribute a notice of privacy practices (as set forth in 45 CFR 164.520); or (c) the patient's right to request privacy restrictions or confidential communications (as set forth in 45 CFR 164.522).

CMS offered some additional information on the operating procedures being relaxed in a fact sheet released on September 6,<sup>49</sup> but it is still unclear what role the Section 1135 waiver authority plays in the context of a program like Medicaid whose day-to-day operations are controlled by the states—especially with regard to payment for services. For example, although CMS has stated that crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid, the agency does not specify *how* they will be paid and whether states, who normally pay providers directly for services rendered to Medicaid beneficiaries and then seek federal reimbursement, *must* pay providers in this situation.

### Applicability of the Secretary's Waiver Authority to Other Disaster Situations

In general, the disaster relief areas and time periods defined in the Secretary's September 2005 waiver actions are aimed at providing targeted relief to individuals and states affected by Hurricane Katrina. As a result, the relief may not apply to individuals and states affected by other emergency situations (e.g., Hurricane Rita). However, in response to a crisis situation, the Secretary may relax provider rules under the Section 1135 waiver authority in *any* state or geographic area that meets certain requirements (as specified above).

Likewise, under the Section 1115 waiver authority, CMS has encouraged Katrina-affected states to pursue waiver programs under their new emergency Section 1115 demonstration initiative.<sup>50</sup> Waiver programs approved under this initiative (as described above) could allow states to offer Medicaid and SCHIP coverage to evacuees from geographic areas in which a disaster or emergency has been declared in response to Hurricane Katrina.<sup>51</sup> While this CMS waiver initiative was specifically targeted at Hurricane Katrina-impacted states, the emergency waiver template may serve as a model for future changes to the Medicaid and SCHIP programs in the wake of a national disaster.

### Current Federal Legislation

A number of bills have been introduced in 109<sup>th</sup> Congress that would affect Medicaid coverage for survivors of Hurricane Katrina (although the bills may address a variety of issues, the discussion below is limited to Medicaid-related provisions).<sup>52</sup> In general, the disaster relief areas and time periods specified in the bills are aimed at providing targeted relief to: (1) individuals and states (or areas within states) directly affected by Hurricane Katrina, and (2) states that have taken in individuals displaced by the storm. As a result, the relief may not apply to individuals and states affected by other emergency situations (e.g., Hurricane Rita).

<sup>49</sup> Centers for Medicare and Medicaid Services, *CMS ACTIONS TO HELP BENEFICIARIES, PROVIDERS IN KATRINA STRICKEN AREAS* (Sept. 6, 2005), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1546>.

<sup>50</sup> Centers for Medicare and Medicaid Services, *Dear State Medicaid Directors and State Children's Health Insurance Program Directors: SHO #05-001, Multi-State Section 1115 Demonstration Application Template Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina* (Sept. 16, 2005).

<sup>51</sup> In the terms and conditions document governing the operation of the recently approved TexKat Section 1115 waiver (described above), CMS reserved the authority to add additional affected National Disaster states or areas for disaster assistance under the Texas waiver program. Amendments to Texas's Section 1115 terms and conditions document to, for example, broaden the definition of evacuee would require CMS approval.

<sup>52</sup> Original co-sponsors are only listed in the case of bipartisan bills.

## House Proposals

### H.R. 3671 (Green)

*Status: Referred to House Committee on Energy and Commerce.*

This proposal would authorize the Secretary of HHS to provide 100% of the federal medical assistance percentage (FMAP) for displaced Medicaid recipients receiving medical assistance outside their state of residence due to a declared public health emergency.

### H.R. 3698 (Dingell)

*Status: Referred to House Committees on Energy and Commerce; Ways and Means.*

This proposal would allow states to receive 100% federal funding for the Medicaid expenditures for individuals who are Katrina survivors (as described by the proposal) and for any individual who is in a directly impacted state (i.e., Alabama, Louisiana, and Mississippi). States may also receive 100% federal funding for administrative costs related to covering Katrina survivors. States that choose to cover Katrina survivors would *not* be allowed to establish income or asset tests or state residency or other categorical requirements. States must also use a simplified application process that would allow individuals to attest that they qualify as a Katrina survivor (individuals would be penalized for knowingly falsely attesting to their status as a survivor). This provision would remain in effect during the disaster relief period from August 29, 2005, through September 30, 2006.

In addition, the proposal would hold *all* states harmless for any scheduled reduction in a state's FMAP rate for FY2006. If a state's FMAP rate for FY2006 is less than it was for FY2005, the FY2005 FMAP rate shall apply.

The proposal would also affect the scheduled changes to Medicaid related to the Medicare prescription drug benefit, effective January 1, 2006. First, the proposal would suspend until January 2007, the requirement for certain states to pay the federal government a portion of what the Medicaid program would have spent on prescription drugs for those dually eligible for Medicaid and Medicare. This provision would only apply to states directly impacted by Hurricane Katrina and those states that have received a "significant influx" of Katrina survivors. The provision would also change federal law to allow state Medicaid programs to pay for prescription drugs for a Part D eligible individual who is also a Katrina survivor. These changes related to the Medicare prescription drug benefit can be ended if the Secretary determines (after consulting with the state) that individuals can be effectively transferred to Medicare for their prescription drug coverage without discontinuing an individual's drug coverage.

### H.R. 3708 (Johnson)

*Status: Referred to House Committees on Energy and Commerce; Transportation and Infrastructure.*

This proposal would require HHS to dedicate 10% of any Hurricane Katrina disaster relief funds for mental health services to victims and first responders. These funds would also be available to cover the state share of Medicaid or SCHIP costs for victims of, or first responders to, Hurricane Katrina.

### H.R. 3735 (Davis)

*Status: Referred to House Committee on Energy and Commerce.*

This proposal would prevent a reduction in a state's FMAP rate for FY2006. No state shall receive a lower FMAP for FY2006 than the greater of the FY2005 FMAP rate, or the

computation of the FMAP formula without the retroactive application of re-benchmarked per capita income.

**H.R. 3845 (Gingrey-Alexander-Boustany-Taylor)**

***Status: Referred to House Committees on Energy and Commerce; Budget.***

This proposal would establish a 90% FMAP rate under Medicaid and SCHIP for FY2006 for Medicaid and SCHIP services provided to individuals in Louisiana or Mississippi, and to Katrina evacuees (as defined by the bill) regardless of their place of residence.

**H.R. 3952 (Gingrey)**

***Status: Referred to House Committees on Energy and Commerce; Ways and Means; Budget; Government Reform; and Transportation and Infrastructure.***

This proposal is similar to S. 1716 in that it would establish Disaster Relief Medicaid (DRM) coverage, provide additional federal Medicaid funding for covering services for Katrina survivors and residents of major disaster parishes and counties, require the Secretary to submit a plan for transitioning drug coverage for Medicare/Medicaid dual eligibles in affected areas from Medicaid to Medicare Part D, and expand the Section 1135 waiver authority.

However, the proposal differs from S. 1716 in several areas. Specifically the proposal would:

- Require Katrina survivors to be eligible for Medicaid based on the criteria used in their state of residence during the week of August 28, 2005 (S. 1716 establishes an income standard of the either 100% of FPL (200% of FPL for certain groups), or the income eligibility that would apply under the state a Katrina survivor currently resides in, whichever is higher);
- Provide 90% federal funding for Medicaid services and related administrative costs for DRM-eligible Katrina survivors during the DRM coverage period (S. 1716 would provide 100% federal funding);
- Provide 90% federal Medicaid funding covering services for residents of major disaster parishes and counties during the period from August 28, 2005 through December 31, 2006, (S. 1716 would provide 100% federal funding);
- Continue Medicaid eligibility redeterminations between August 28, 2005 and December 31, 2006, (S. 1716 would establish a moratorium on redeterminations);
- Exclude treatment of alcohol and substance abuse that is directly related to the circumstances of Hurricane Katrina from the extended mental health and care coordination benefit;
- For Katrina survivors, temporarily waive Medicaid's prohibition on covering services in an institution for mental disease (IMD) for adults between ages 21 and 64 beginning on August 28, 2005 and ending on December 31, 2006.

**H.R. 3958 (Melancon)**

***Status: Referred to House Committees on Appropriations; Agriculture; Transportation and Infrastructure; Budget; Financial Services; Energy and Commerce; Judiciary; Armed Services; Education and the Workforce; Resources; and Small Business.***

This proposal is similar to S. 1716 in that it would establish Disaster Relief Medicaid (DRM) coverage, provide 100% federal Medicaid funding for DRM-eligible Katrina survivors, hold all states harmless for FMAP decreases in FY2006, require the Secretary to submit a plan for

transitioning drug coverage for Medicare/Medicaid dual eligibles in affected areas from Medicaid to Medicare Part D, and expand the Section 1135 waiver authority.

However, most provisions in this proposal would only apply to Louisiana (provisions of S. 1716 include certain counties in Mississippi and Alabama). DRM coverage is for Katrina survivors from Louisiana. The additional federal Medicaid funding for major disaster areas and the moratorium on Medicaid eligibility redeterminations would only apply to Louisiana.

Another difference between this proposal and S. 1716 is that the Disaster Relief Fund would have an appropriation of \$400 million and would be available only to pay for private health insurance premiums. In a separate provision, during the DRM coverage period,<sup>53</sup> expenditures of the state of Louisiana for reimbursing hospitals, physicians, federally qualified health centers, and rural clinics for uncompensated care provided to Katrina survivors would be treated as medical assistance under Louisiana's Medicaid state plan, with an FMAP of 80%.

#### **H.R. 4197 (Watt)**

***Status: Referred to House Committees on Ways and Means, Judiciary, Financial Services, Energy and Commerce, Transportation and Infrastructure, Education and the Workforce, Small Business, Government Reform, and Budget.***

This proposal would provide Disaster Relief Medicaid (DRM) coverage similar to that described in S. 1716—except that the DRM coverage period would last 12 months, with a discretionary 12-month extension by the President.

### **Senate Proposals**

#### **S. 1637 (Reid)**

***Status: Referred to Senate Committee on Finance.***

Similar to H.R. 3698, except that the disaster relief period is from August 29, 2005, through February 28, 2006 (though the President must extend through September 30, 2006, unless a determination is made that all Katrina survivors have sufficient access to health care).

#### **S.A. 1652 to H.R. 2862 (Lincoln)**

***Status: Amendment withdrawn.***

Similar to S. 1637.

#### **S.A. 1672 to H.R. 2862 (Durbin)**

***Status: Amendment submitted, but no action taken.***

This proposal allows certain health professionals to provide Medicaid services in Florida, Alabama, Louisiana, Mississippi and Texas without regard to state licensing and certification laws for 90 days following enactment of the provision.

#### **S.A. 1721 to H.R. 2862 (Durbin)**

***Status: Agreed to in Senate as part of H.R. 2862.***

This proposal would allow eligible health professionals (as defined by the bill) that have been evacuated from Louisiana and Mississippi to provide health-related services under Medicare, Medicaid or SCHIP and under Indian Health Service programs, without regard to state licensing and certification laws for 90-days following the date specified by a state's licensing board.

<sup>53</sup> For this bill provision, the language "during the DRM coverage period that begins on April 30, 2005" is used. Earlier in the bill, the DRM coverage period is defined as beginning on August 28, 2005.

**S. 1688 (Hutchison)*****Status: Placed on Senate legislative calendar.***

This proposal would allow any state to receive 100% federal funding for Medicaid and SCHIP expenditures for individuals (children in the case of SCHIP) who are Katrina survivors (as described by the proposal) during the disaster period in the area of the survivor's residence (or former residence).

The disaster period for a state is determined by the date an area(s) in the state were declared a major disaster area in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act because of Hurricane Katrina. The disaster period ends on the earlier of: (1) the latest date an area of that state is designated as a major disaster area; or (2) six months following the declaration of the disaster area. The President may extend the disaster period for a state for up to an additional six months.

States that choose to cover Katrina survivors would not be allowed to establish income or asset tests or state residency or other categorical requirements. States must also use a simplified application process that would allow individuals to attest that they qualify as a Katrina survivor (individuals would be penalized for knowingly falsely attesting to their status as a survivor).

Katrina survivors would be eligible for the same range and scope of services as those who are categorically needy under the Medicaid program, or as a targeted low-income child under the SCHIP program. In addition, the state must pay for medical services (including mental health services) that are outside the scope of the state's Medicaid coverage if the item or service is medically necessary for the survivor.

**S. 1716 (Grassley-Baucus)*****Status: Placed on Senate legislative calendar.***

This proposal would require states to provide Disaster Relief Medicaid (DRM) coverage for individuals who are Katrina survivors (as defined by the bill) and meet specific income guidelines. To qualify, a Katrina survivor's family income cannot exceed the higher of either 100% of the federal poverty level (FPL) (200% FPL in the case of pregnant women, children, and recipients of Social Security Disability Insurance (SSDI) benefits); or the income eligibility standard under the state's Medicaid state plan. The state would be required to use the least restrictive income counting rules applied in that state and must disregard unemployment compensation from income. States would not be allowed to establish asset tests or state residency or other categorical requirements. States must use a simplified application process that would allow individuals to attest that they qualify as a Katrina survivor (individuals would be penalized for knowingly falsely attesting to their status as a survivor).

The DRM coverage period would be from August 28, 2005 until five months after the date of enactment of the bill, subject to a discretionary five-month extension by the President. During the DRM coverage period, the state would be allowed to provide extended mental health and care coordination benefits to DRM-eligible Katrina survivors. The state would also be allowed to provide home and community-based waiver services to individuals who self-attest that they require immediate services available under the waiver. The Secretary of HHS would lift waiver restrictions (as specified in the bill) that limit the availability of such services.

States would receive 100% federal funding for Medicaid service expenditures and administrative costs associated with DRM-eligible Katrina survivors during the DRM coverage period. For items and services furnished during the period that begins on August 28, 2005, and ends on December 31, 2006, a 100% FMAP would be available for providing medical assistance under a Medicaid state plan to any individual, including a Katrina survivor, residing in a parish or county



for which the President has declared a major disaster pursuant to the Stafford Act as a result of Hurricane Katrina and determined that individual or public assistance is warranted. The bill would also hold all states harmless for any scheduled reduction in their FMAP for FY2006. If a state's FY2006 FMAP is less than it was for FY2005, the FY2005 FMAP shall apply.

The bill would also establish a Disaster Relief Fund (with an appropriation of \$800 million for FY2005, to remain available until expended) administered by the Secretary of HHS. The Disaster Relief fund would: (1) make payments directly to certain Medicaid providers to offset costs incurred as a result of Hurricane Katrina, (2) make payments to state insurance commissioners for the purpose of making health insurance premium payments to insurers on behalf of certain individuals and employers.

The bill would also require the Secretary of HHS to submit to Congress no later than October 7, 2005 a written plan on the transition of individuals who are dually eligible for Medicaid and Medicare from Medicaid prescription drug coverage to coverage under the new Medicare Part D prescription drug benefit.

Finally, the bill would amend Section 1135 to extend waiver authority to geographic areas that the Secretary of HHS determines have a significant number of evacuees from an emergency area. The amendment would be effective as if enacted on August 28, 2005.

#### **S. 1765 (Landrieu-Vitter)**

***Status: Referred to Senate Committee on Finance.***

This proposal is similar to S. 1716 in that it would establish Disaster Relief Medicaid (DRM) coverage, provide 100% federal Medicaid funding for DRM-eligible Katrina survivors, hold all states harmless for FMAP decreases in FY2006, require the Secretary to submit a plan for transitioning drug coverage for Medicare/Medicaid dual eligibles in affected areas from Medicaid to Medicare Part D, and expand the Section 1135 waiver authority.

This proposal differs from S. 1716 in that during the period that begins on August 28, 2005, and ends on December 31, 2006, a 100% FMAP would be available for providing medical assistance under a Medicaid state plan to any individual (including a Katrina survivor) residing only in a parish in Louisiana for which the President has declared a major disaster pursuant to the Stafford Act as a result of Hurricane Katrina and determined that individual or public assistance is warranted (a similar provision in S. 1716 would include counties in Mississippi and Alabama).

Another difference between this proposal and S. 1716 is that the Disaster Relief Fund would have an appropriation of \$400 million and would be available only to pay for private health insurance premiums. In a separate provision, during the DRM coverage period,<sup>54</sup> expenditures of the state of Louisiana for reimbursing hospitals, physicians, federally qualified health centers, and rural clinics for uncompensated care provided to Katrina survivors would be treated as medical assistance under Louisiana's Medicaid state plan, with an FMAP of 80%.

#### **S. 1766 (Vitter-Landrieu)**

***Status: Referred to Senate Committee on Finance.***

Same as S. 1765.

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<sup>54</sup> For this bill provision, the language "during the DRM coverage period that begins on April 30, 2005" is used. Earlier in the bill, the DRM coverage period is defined as beginning on August 28, 2005.



## Budget Reconciliation

In the FY2006 budget resolution adopted by the House and Senate on April 28, 2005 (H.Con.Res. 95), reconciliation instructions directed the two committees with jurisdiction over Medicaid to reduce mandatory FY2006-FY2010 outlays by \$10 billion (Senate Finance) and \$14.734 billion (House Energy and Commerce). While the budget resolution did not instruct the two committees on how to achieve these savings targets, Medicaid is one of the larger mandatory spending programs that falls under their jurisdictions.

### *Senate*

On October 25, 2005, the Senate Finance Committee approved a reconciliation proposal that the Senate Budget Committee incorporated into S. 1932, which subsequently passed the Senate on November 3. Under one provision of S. 1932, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to individuals who resided during the week preceding Hurricane Katrina in one of the parishes or counties of Louisiana, Mississippi, and Alabama specified in the bill.<sup>55</sup> Costs directly attributable to related administrative activities would also be reimbursed at 100%. Another provision of S. 1932 would allow Louisiana, Mississippi, and Alabama to elect to not have the Medicaid subtitle of the bill (e.g., changes dealing with prescription drugs) apply during any period for which a disaster declared as a result of Hurricane Katrina remains in effect.

### *House*

On October 28, 2005, the House Energy and Commerce Committee approved its own reconciliation proposal. The House Budget Committee incorporated the proposal into H.R. 4241, which subsequently passed the House as an amendment to S. 1932 on November 18. Under the House bill, for items and services furnished between August 28, 2005 and May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to (1) any individual residing in a parish of Louisiana, a county of Mississippi, or a major disaster county of Alabama and (2) individuals who resided during the week preceding Hurricane Katrina in a parish or county for which a major disaster has been declared as a result of Katrina—and for which the President has determined, as of September 14, 2005, warrants individual assistance under the Stafford Act.<sup>56</sup> Costs directly attributable to related administrative activities would also be reimbursed at 100%.

In addition, for any year after 2006 for any states that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their income for purposes of calculating state FMAPs for Medicaid and SCHIP. Another provision of

<sup>55</sup> The parishes (31 in Louisiana) and counties (47 in Mississippi, 11 in Alabama) specified in S. 1932 appear to be those that had been designated for individual assistance under the Stafford Act following Hurricane Katrina as of the date the Senate Finance Committee approved its reconciliation proposal (October 25, 2005). On October 27, two additional counties in Mississippi were designated for individual assistance. These counties are not listed in the bill.

<sup>56</sup> According to *Federal Register* notices from FEMA, 31 parishes in Louisiana, 47 counties in Mississippi, and 10 counties in Alabama had been designated for individual assistance following Hurricane Katrina as of September 14, 2005. This particular provision of the House proposal excludes one county in Alabama (whose individual assistance designation was granted on October 5) that was included in a similar provision of the Senate Finance Committee proposal (see previous footnote). For more information on county designations following Hurricane Katrina, see <http://www.fema.gov/news/eventdfns.fema?id=4808> for Louisiana, <http://www.fema.gov/news/eventdfns.fema?id=4807> for Mississippi, and <http://www.fema.gov/news/eventdfns.fema?id=4825> for Alabama.

the House bill would allow the Medicaid subtitle of the bill to not apply during the 11-month period beginning September 1, 2005, to individuals entitled to Medicaid assistance by reason of their residence in a parish of Louisiana or a county of Mississippi or Alabama for which a major disaster has been declared as a result of Hurricane Katrina—and for which the President has determined, before September 14, 2005, warrants individual and public assistance under the Stafford Act.

### ***Conference***

A conference report on S. 1932 (H.Rept. 109-362) containing Hurricane Katrina Medicaid and SCHIP relief was filed on December 19. The House agreed to the report by a vote of 212-206 that day. On December 21, the Senate removed extraneous matter from the legislation pursuant to a point of order raised under the “Byrd rule,” and then, by a vote of 51-50 (with Vice President Cheney breaking a tie vote), returned the amended measure to the House for further action.

The conference agreement would appropriate \$2 billion (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those that have provided care to affected individuals or evacuees under a Section 1115 project) for the following purposes:

- the non-federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals who have been displaced to another state) under approved multi-state Section 1115 demonstration projects;
- reasonable administrative costs related to such projects;
- the non-federal share of expenditures for medical assistance provided to individuals under existing Medicaid and SCHIP state plans; and
- other purposes, if approved by the Secretary, to restore access to health care in affected communities.

The non-federal share paid to eligible states would not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations would be incurred under approved multi-state Section 1115 projects for the following costs: (1) health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006, and (2) uncompensated care or services and supplies beyond those included as Medicaid or SCHIP medical assistance incurred after January 31, 2006.

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